

**ADULT FOSTER CARE LICENSE
INDIVIDUAL APPLICATION**
Michigan Department of Human Services
Office of Children and Adult Licensing

FOR DHS USE ONLY:

License Number:

Paid Amount:

Cashier:

SECTION I – FACILITY INFORMATION

For OCAL Use ONLY: Consultant Load #

1. Facility Name		2. Application Type <input type="checkbox"/> Original <input type="checkbox"/> Renewal <input type="checkbox"/> Amended		3. License Number	
4. Facility Street Address		5. City/Village	6. Township	7. State	8. Zip Code
9. County	10. Zoning Authority <input type="checkbox"/> Township <input type="checkbox"/> City/Village	11. Telephone Number ()	12. Fax Number ()	13. New Construction <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Proposed Capacity	15. I would prefer: <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both	16. Ages	17. Currently Certified As A Specialized Program or Requesting Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. Program Type(s) <input type="checkbox"/> Mentally Ill <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Aged <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Wheelchair Accessible <input type="checkbox"/> Physically Handicapped <input type="checkbox"/> Traumatic Brain Injured			19. Water System <input type="checkbox"/> Public <input type="checkbox"/> Private		20. Sewer System <input type="checkbox"/> Public <input type="checkbox"/> Private
21. Facility Type <input type="checkbox"/> Family Home 1-6 <input type="checkbox"/> Small Group 1-6 <input type="checkbox"/> Small Group 7-12 <input type="checkbox"/> Large Group 13-20 <input type="checkbox"/> Congregate 21 or more – EXISTING ONLY					

SECTION II – APPLICANT LICENSEE INFORMATION

All original applicants must complete a Licensing Record Clearance Request form.

22. Applicant Name		23. Social Security or Federal Tax ID Number		24. Telephone Number ()	
25. E-mail Address				26. Fax Number ()	
27. Street Address			28. City	State	Zip Code
29. Mailing Address, if different (i.e. P.O. Box)			City	State	Zip Code
30. Joint Applicant Name (if applicable)		31. Social Security or Federal Tax ID Number		32. Telephone Number ()	
33. E-mail Address				34. Fax Number ()	
35. Street Address			36. City	State	Zip Code
37. Mailing Address, if different (i.e. P.O. Box)			City	State	Zip Code

SECTION III – RESPONSIBLE AGENCY INFORMATION (If Applicable) Attach Additional sheets, if necessary

38. Agency Name and Address	39. Name of Contact Person	40. Telephone Number

SECTION IV – ADMINISTRATOR or RESPONSIBLE PERSON INFORMATION**Administrators must complete a Licensing Record Clearance Request form.**

41. Group Home/Congregate Applicants. Print Name of Person Responsible for Daily Operation of the Facility (Administrator)

42. FAMILY HOME APPLICANTS ONLY: Provide the name(s) of at least one responsible adult, other than the applicant or joint applicant, who can provide up to 72 hours of emergency coverage for you. Responsible persons must have proof of current T.B. test results and a physician's statement that they are both physically and mentally capable of caring for and being around residents.

Name (Last, First, Middle)	Street Address (city, state and zip)	Telephone Number

43. Describe any convictions of the applicant, joint applicant, administrator, and non-employee adult members of the household. Do not include minor traffic violations.

44. Has the applicant or joint applicant now, or ever, operated an adult foster care facility, children's foster care facility, children's day care facility, child caring institution, child placing agency, or adult or children's camp? If "yes" please complete Item 46. ☐ Yes ☐ No45. Have you ever been denied a license to operate an adult foster care facility, children's foster care facility, children's day care facility, child caring institution, child placing agency, or adult or children's camp? If "yes" please complete Item 46. ☐ Yes ☐ No

46. If "YES" to either Item 44 or 45, complete the following information. Include all currently and previously licensed programs and denied license applications. Attach additional sheets, if necessary.

Name of licensing/certifying agency	Type of care	License Number	Application Date	Open	Closed

47. Provide the following information for all persons who live in the facility, including relatives, roomers and boarders and live-in staff and children. Do not include adult foster care residents. All non-employee adult household members who are not residents must complete a Licensing Record Clearance Request form.

Name (Last, First, Middle)	Position or Relationship	Date of Birth

48. Directions for reaching family from Office of Children and Adult Licensing field office.

SECTION V – OWNERSHIP INFORMATION

49. Identify all ownership interest in the business. Include additional sheets if necessary.

NAME	ADDRESS (City, State and Zip Code)

50. Ownership of facility to be licensed: ☐ Own ☐ Rent/Lease ☐ Buying

51. Identify all ownership interest in the property. Include additional sheets, if necessary.

NAME	ADDRESS (City, State and Zip Code)

SECTION VI – FINANCIAL INFORMATION

All questions must be answered by the Applicant and Joint Applicant to the best of his/her knowledge. Attach an explanation for each question answered "Yes."

52. HAS THE APPLICANT OR JOINT APPLICANT EVER:

- | | | | |
|--|--|--|--|
| a. Filed for Bankruptcy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Had a default judgement against it? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Had a seizure of assets? | <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Had a repossession or foreclosure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Had a lien enforced against it? | <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Had a notice of eviction due to payment problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Had financial assets frozen? | <input type="checkbox"/> Yes <input type="checkbox"/> No | i. Had a garnishment or attachment of wages or income? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Had a contract to receive public or private monies not renewed or terminated prior to its expiration? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

53. FOR FAMILY HOME APPLICANTS ONLY:

A. ☐ **I have sufficient resources to meet Rule 400.1404(4).** The department defines "sufficient resources as follows:

Original applicants have financial assets available to provide for the operation of the home for a period of at least three months.

Renewal applicants have financial assets available to provide for the operation of the home for a period of at least 30 days.

These resources are from: (check all that apply)

- ☐ Applicant/Joint Applicants employment outside of adult foster care
- ☐ Non-Applicant/Joint Non-Applicant spouse's income
- ☐ Savings or available cash
- ☐ Funding contracts/Intent to contract statement
- ☐ Adult foster care income
- ☐ Other, specify

Please attach an explanation of all items checked. You may be required to provide verification and/or documentation of the financial information provided.

B. ☐ I do not have sufficient resources at this time to meet Rule 400.1404(4). *You may submit additional information for consideration.*

Section VII – CERTIFICATION AND SIGNATURES

I have read PA 218 of 1979, as amended, and the Administrative Rules regulating the operation of Adult Foster Care facilities. If granted a license I will comply with the Act and these Rules.

In order to permit a proper determination of conformity with the rules, I give permission to the Department of Human Services to make all necessary and reasonable investigations of my activities, proposed standards of care, and to make an on-site inspection of the proposed facility.

I am aware of the legal provisions of Section 13 and Section 31 of PA 218 of 1979, respectively, that operating an adult foster care facility without a license or to violate this Act is subject to criminal penalties, punishable by imprisonment or a substantial fine or both.

I certify that I will assess the good moral character of the employees of this home/facility, as required by PA 218. I certify that if I or any employee, volunteer, or household member of the facility who is on parole or probation or convicted of a felony will be reported to the Department.

I also certify that any information I give in respect to any investigation by the department will be, to the best of my ability, true and correct.

54. Applicant Name (print or type)	55. Applicant Signature	56. Date
57. Joint Applicant Name (print or type)	58. Joint Applicant Signature	59. Date

A LICENSEE FEE (which is non-refundable and non-transferable), payable by check or money order **ONLY**, to the **STATE OF MICHIGAN**, is to be sent in accordance with the Application Instructions. The fees are:

	<u>ORIGINAL</u>	<u>RENEWAL</u>		<u>ORIGINAL</u>	<u>RENEWAL</u>
Family Home 1 – 6	\$ 65.00	\$25.00	Large Group Home 13 – 20	\$170.00	\$100.00
Small Group Home 1 – 6	\$105.00	\$25.00	Congregate Facility 21+	\$220.00	\$150.00
Small Group Home 7 – 12	\$135.00	\$60.00			

The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an DHS office in your area.	AUTHORITY: Public Act 218 of 1979, as amended COMPLETION: Mandatory NON-COMPLETION: License issuance will be denied
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